Shashi Lodhia CMLDT, LMBT11844 **Client Intake Questionnaire** Wake Medical Massage, LLC

Name _____ Today's Date: _____/_____/_____

Address _____ City _____ State ____ Zip _____

Home Phone # _____ Work Phone # _____ Cell # _____

Occupation _____ Company Name _____

Marital Status _____ Sex: M / F Date of Birth: ____ / ___ / _____ Email: _____

Would you like to receive discount coupons or information on future promotions by Email? Yes / No

Emergency Contact Name _____ Phone _____

How did you learn about us? _____

Have you had a massage before? _____

Reason(s) for therapeutic massage today:_____

Are you receiving current medical treatment that would effect your massage_____

Your personal physician's name_____

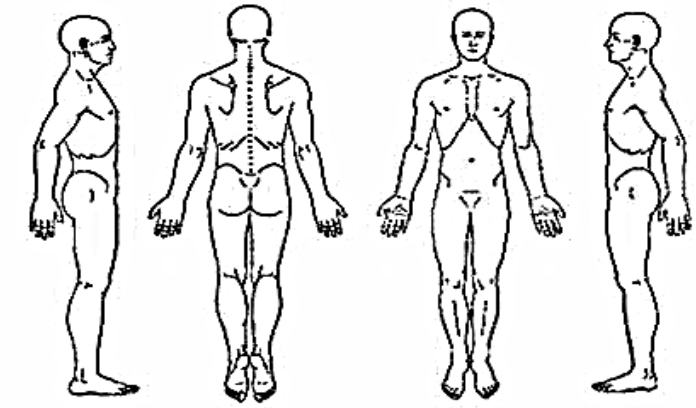
Specific Conditions:_____

Have you ever had or do you have any of the following conditions: **Please circle**:

Yes No Heart or circulation problem
Yes No High Blood Pressure
Yes No Varicose veins
Yes No Diabetes
Yes No Frequent headaches
Yes No Migraine headaches
Yes No Convulsions
Yes No Cancer
Yes No Depression

Yes No Fibromyalgia diagnosed
Yes No Broken bones
Yes No Dislocation/separation of extremity (ies)
Yes No Bulging/ruptured disc(s)
Yes No Numbness or tingling
Yes No Are you wearing contact lenses
Yes No Sensitive to touch/pressure

Please indicate areas of pain, tension, and/or other uncomfortable conditions.



Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required to service being provided. I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature: _____ Date:_____